

State of California
MH 2180(1/07)

Department of Mental Health

MEDI-CAL (M/C) CERTIFICATION AND TRANSMITTAL

Part A: Provide the following information:
1407138407

NPI#

COUNTY SUBMITTING FORM: PLACER

COUNTY CODE: 31

TYPE OF TRANSACTION (Check all that apply) Activate Terminate Change Re-Cert
If change, indicate one or more types: Name Address Mode/SF Effective Date

PROVIDER NUMBER: 31BE

PROVIDER NAME: TURNING POINT COMMUNITY PROGRAMS

PROVIDER ADDRESS: 101 CIRBY HILLS DRIVE

PROVIDER CITY: ROSEVILLE

PROVIDER ZIP CODE: 95678-4360

M/C ACTIVATION DATE: 9/20/2011

M/C TERMINATION DATE:

M/C RECERT DATE:

IF CHANGE, EFFECTIVE DATE OF CHANGE:

Per the MHP Contract, the M/C activation date cannot be earlier than the latest date of the following dates:

- 1) Date the site was operational: 9/20/11
- 2) Date of the fire clearance: 9/14/11
- 3) Date the provider requested certification: 9/1/11

In addition, the onsite review must be within six months of these dates. Date of onsite review: 9/20/11

Is the county submitting this form, the host county? yes no If no, name host county:

Indicate services	Revenue/Procedure Code (CR/DC Mode, Service Function)			
<input type="checkbox"/> (07) General Hospital	0100 (05/10)	0101 (05/19)	<input type="checkbox"/> Non-Hospital PHF	H2013 (05/20)
<input type="checkbox"/> (08) Psych Hosp Age (< 21)	0100 (05/10)	0101 (05/19)	<input type="checkbox"/> Crisis Residential	H0018 (05/40)
<input type="checkbox"/> (09) Psych Hosp Age (> 64)	0100 (05/10)	0101 (05/19)	<input type="checkbox"/> Adult Residential	H0019 (05/85)

For Residential - How many beds? _____

Check only one Mode (either 12 or 18): (12) Hospital Outpatient (18) Non-Hospital Outpatient

Indicate services	Procedure Code (CR/DC Mode, Service Function)		(Check all that apply)
<input type="checkbox"/> Crisis Stabilization ER	S9484 (10/20)	<input type="checkbox"/> Crisis Stabilization UC	S9484 (10/25)
<input type="checkbox"/> Day TX Intensive Half Day	H2012 (10/81)	<input type="checkbox"/> Day TX Intensive Full Day	H2012 (10/85)
<input type="checkbox"/> Day Rehab. Half Day	H2012 (10/91)	<input type="checkbox"/> Day Rehab. Full Day	H2012 (10/95)
<input type="checkbox"/> Case Manage./Brokerage	T1017 (15/01)	<input type="checkbox"/> MHS H2015 (15/30)	<input type="checkbox"/> TBS H2019 (15/58)
<input checked="" type="checkbox"/> Medication Support	H2010 (15/60)	<input type="checkbox"/> Crisis Intervention H2011 (15/70)	

The above named provider is certified by this agency to participate in the Short-Doyle/Medi-Cal program. I attest that the above named provider site complies with requirements of the CCR, Title 9, Sections 1810.435-436, the terms of the contract between the MHP and the Department.

Margaret Chambers

Print name of person completing form.

County Fax: (530) 886-1866

Margaret Chambers
Authorized Signature.

Phone: (916) 787-8885 Date: 9/20/11

Check below to indicate person signing.

- County Mental Health Director or Designee
- Medi-Cal Oversight

To be submitted to Medi-Cal Oversight for signature below.

Part B: Medi-Cal Oversight Approval to Transmit Data to DHS

S. Hochman

Medi-Cal Oversight

Date: 10-7-11